Interjurisdictional Tuberculosis Notification

Referring Jurisdiction City County State Date sent

Contact person Phone ( ) FAX ( )

☐ Verified case→State where reported: RVCT# (attach RVCT) ☐Not reported

☐ Suspect case ☐Close contact ☐Reactor LTBI ☐Convertor ☐Source case investigation

Patient name Last, First, Middle Sex ☐Male ☐Female

Date of birth Interpreter needed? ☐No ☐Yes, specify language

New address Number/Street/Apt.

City/State/ZipCode

Hispanic ☐No ☐Yes

Race ☐ White ☐Black ☐Asian ☐Am.Indian/Nat.Alaskan. ☐Other:

New telephone ( ) Date of expected arrival

New health provider: ☐ Unknown ☐Known (name, address, phone)

Insurance source: ☐None ☐Medicaid ☐Private ☐Medicare ☐Other

Emergency contact: Name Phone

Laboratory information for ☐ this referred case/suspect ☐index case for this contact ☐not applicable

Date	Specimen type	Smear	Culture	Susceptibility	Chest X-ray	Other pertinent labs

Site(s) of disease: ☐ Pulmonary ☐Other(s) specify all

Date 1st negative smear ☐Not yet Date 1st negative culture ☐Not yet

TB skin test #1:Date Result mm TB skin test #2: Date Result mm

Contact/LTBI Information **TB Skin test** ☐Not Done

TST #1 Date Result mm TST#2 Date Result mm

CXR ☐ Not Done Date ☐Normal ☐Other:

Last known exposure to index case Place/intensity of exposure:

Medications for this referred Case Planned Completion Date:

Drug	Dosage	Start date	Stop Date

DOT ☐ NO ☐ Yes Start Date:

☐ Daily ☐ 1xW ☐ 2xW ☐ 3xW

Last DOT Date:

Comments

Case Follow-Up In 30 days report to referring jurisdiction if located or not located and report final outcome.

Other Follow-Up ☐ Follow-up requested (form attached) ☐No follow-up requested